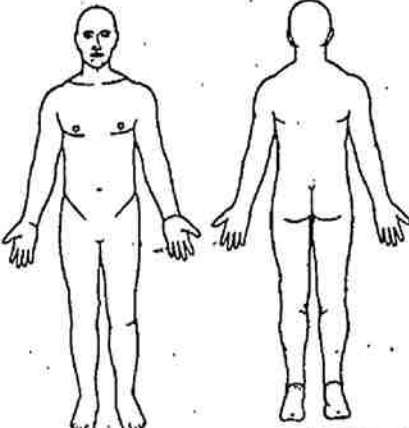


Adult Outpatient Musculoskeletal (MSK) Physiotherapy  
**Patient Completed Self Referral Form**



Please complete all parts of this form and hand in or send to local Physiotherapy department

Date	Name		M <input type="checkbox"/> F <input type="checkbox"/>
Address		Date of Birth:	
Post Code	Occupation		
Telephone (home)	(work)	(mobile)	
GP Name	GP Address		
Do you have any special requirements? (e.g. interpreter) No <input type="checkbox"/> Yes <input type="checkbox"/>			
Please describe:			
		Please mark on the diagram the location of your problem. Where is your pain? Is your pain / problem due to a recent fall or injury? No <input type="checkbox"/> Yes <input type="checkbox"/> Please describe your current problem and symptoms below:	
How long have you had your current problem?		If more than 3 months, please state how long:	
Less than 2 weeks <input type="checkbox"/> 2 - 6 weeks <input type="checkbox"/> 7 - 12 weeks <input type="checkbox"/>			
Is your problem getting? Worse <input type="checkbox"/> Better <input type="checkbox"/> Not changing <input type="checkbox"/>			
If in pain, how would you describe it? Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>			
Is your pain constant (present ALL the time)? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Is pain disturbing your sleep? Yes, difficulty getting to sleep <input type="checkbox"/> Yes, woken up from sleep <input type="checkbox"/> Yes, unable to sleep at all <input type="checkbox"/> No <input type="checkbox"/>			
Are you off work because of this problem? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes how long:			
Are you unable to care for / look after someone because of this problem? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Is your problem from an injury sustained during active military service? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Are your day to day activities affected by your pain? Not at all <input type="checkbox"/> Mildly <input type="checkbox"/> Moderately <input type="checkbox"/> Severely <input type="checkbox"/>			
Please consult your GP <b>URGENTLY</b> or NHS 24 on telephone number: <b>08454 24 24 24</b> if you have <u>recently or suddenly</u> developed: <ul style="list-style-type: none"> <li>• difficulty passing urine or controlling bladder / bowels</li> <li>• numbness or tingling around your back passage or genitals</li> <li>• numbness, pins and needles or weakness in both legs</li> </ul>		Please inform your GP of this referral if you: <ul style="list-style-type: none"> <li>• have recently become unsteady on your feet</li> <li>• are feeling generally unwell / fever</li> <li>• have a history of cancer</li> <li>• have any unexplained weight loss</li> </ul>	